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August 12, 2010

Susan Broetje, Administrator
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **July 23, 2010**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004696

Allegation #1: Individuals are repeatedly injured during restraint.

Findings #1: An unannounced on-site complaint investigation was conducted on 7/22/10 and 7/23/10. During that time, observations were conducted, investigations and individuals' records were reviewed, and interviews with individuals and direct care staff were conducted with the following results:

Observations were conducted on 7/22/10 and 7/23/10 for a cumulative 6 hours 41 minutes. During that time, no individuals were noted to be placed in restraints and no individuals were noted to have any observable injuries.

Seventy one (71) investigations, dated 1/1/10 - 7/21/10, were reviewed. Of those 71 investigations, one (1) investigation was related to an individual sustaining significant injuries during two separate restraints. The investigation showed that on 12/5/09, the individual was restrained. After the restraint, the individual reported discomfort in his right knee to the nurse. The investigation showed the nurse observed some swelling to his right knee. Prone restraint was discontinued that day

(12/5/09), and the individual was advised to ice and elevate his leg and use pain medication as needed. The investigation showed that on 12/8/09, the individual was examined by the doctor and an x-ray was taken which showed the individual had a fracture to his right knee. The investigation showed the individual had surgery to repair his knee. The investigation showed the doctor was interviewed and stated that during the 12/8/09 examination, swelling and tenderness was found but no bruising, and it was highly unlikely that a restraint could cause that type of injury. The investigation showed the individual was interviewed about the injury to his knee and he reported three different events: 1) He stated that on 12/4/09, he fell on the ice while walking to work; 2) He stated that on 12/5/09, he tripped and fell and while struggling during a restraint and a staff fell on him; and 3) He fell and scraped his elbow on 12/8/09 after being startled by maintenance workers who passed by him in a golf cart. The investigation showed that on 4/29/10, the same individual was placed in a stand restraint when he reached back with his right hand and forcefully pulled staff's hair causing both the staff and the individual to fall to the floor. The investigation showed the individual broke the forth digit on his left hand which required surgical repair.

Ten (10) individuals' records were reviewed. Nine (9) records documented minor injuries (scratches) were sustained during restraints. One record documented an individual sustained one (1) significant injury from restraint; a broken finger. The same individual sustained an injury to his knee that was originally suspected of being from restraint, which was investigated by the facility. The investigation showed it was improbable that the injury was sustained during restraint. Both injuries required surgical repair.

During the course of the survey, eleven (11) individuals agreed to be interviewed. Ten individuals stated they had not received any injuries during restraint. One individual stated he was injured twice; once when he grabbed a staff person's hair and his fingers got tangled in the staff's hair. The individual stated the second injury occurred when he tripped and fell on his knee, and while struggling with a staff person, the staff fell on top of him.

Thirty two (32) direct care staff were interviewed. All staff consistently reported that if an individual required restraint, the nurse was required to perform a skin check afterwards and all injuries were documented by the nurse in the individual's chart. All staff reported they actively tried to avoid restraint as the facility was in process of restraint reduction and all prone restraints required formal investigation.

Therefore, the allegation was unsubstantiated and no deficient practice was

identified.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals are required to attend vocational programs when injured.

Findings #2: An unannounced on-site complaint investigation was conducted on 7/22/10 and 7/23/10. During that time, observations and interviews with individuals and direct care staff were conducted, and individuals' records were reviewed with the following results:

Observations were conducted on 7/22/10 and 7/23/10 for a cumulative 6 hours 41 minutes. During that time, no individuals were noted to be required to attend vocational programming. Further, no individuals were noted to be ill or injured. Three (3) individuals were noted to refuse to go to work. When asked, the individuals stated "I don't feel like working today."

Eleven (11) individuals agreed to be interviewed. All individuals stated they were not required or forced to attend vocational programming. The individuals stated if they were ill or injured, the nurse gave them a medical excuse. The individuals reported they were encouraged to go to work but they had the right to refuse. They stated if they chose to stay on the living unit, they were encouraged to complete household chores but they could refuse to help. One individual reported he was fired from his job because he refused to go to work for 19 days. The individual stated it was "real life" and someone else wanted the job. The individual stated he did not care as he was looking forward to being discharged in the next couple of weeks.

Thirty two (32) direct care staff were interviewed. All staff consistently reported individuals were not required or forced to attend vocational programming. Staff stated if an individual was ill or injured, they were medically excused from work by the nurse. Staff consistently stated if an individual chose to stay on the living unit, they were encouraged to complete household chores but they had the right to refuse to participate.

Ten (10) individuals' records were reviewed. None of the records showed individuals were required to or actually did attend vocational programming when ill or injured.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Staff do not follow hierarchies of least restrictive interventions prior to implementing restraint.

Findings #3: An unannounced on-site complaint investigation was conducted on 7/22/10 and 7/23/10. During that time, observations were conducted, investigations, restraint data, and individuals' records were reviewed, and interviews with individuals and direct care staff were conducted with the following results:

Observations were conducted on 7/22/10 and 7/23/10 for a cumulative 6 hours 41 minutes. During that time, no individuals were noted to engage in maladaptive behavior and restraints were not noted to be used.

Seventy one (71) investigations, dated 1/1/10 - 7/21/10, were reviewed. None of the investigations documented restraint being used prior to less restrictive interventions. Restraint data, dated 1/1/10 - 7/21/10, was also reviewed. The data contained documented evidence of less restrictive interventions being implemented prior to the use of restraint.

Ten (10) individuals' records were reviewed. Those records contained written plans showing the progression of less restrictive interventions to be used prior to the use of restraint.

Eleven (11) individuals agreed to be interviewed. All individuals reported least restrictive interventions were always tried by the staff before using restraint.

Thirty two (32) direct care staff were interviewed. All staff consistently reported they were required to follow individuals' behavior plans. Staff reported all behavior plans contained a hierarchy, starting with the least restrictive interventions and ending with the most restrictive interventions, that was approved for each individual. All staff reported they were required to always start with the least restrictive intervention. Staff reported the facility had an active plan for restraint reduction and restraint was used as a last resort.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srp